Watford Community Safety Partnership

Domestic Homicide Overview report into the death of Anna, December 2019

Official

Chair and author: Elizabeth Hanlon

Review completed: February 2022

Submitted to the Home Office: March 2022

Contents

Anna

“Anna was born in Poland and moved to England in 2006. She was a wonderful mum, wife, daughter, and sister. She was family-orientated, and loved her family greatly, always providing food for daily meals. She particularly loved to eat nuts and waffles.

Anna had a bubbly personality, was very friendly and hardworking - laughing and smiling often with family and work colleagues.

We all miss her terribly and think of her often.”

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Anna, a resident of Watford, prior to the point of her death in December 2019. Anna was killed by her son, Tomasz, who was aged 17 years at the time of the murder.

1.2 'In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 The key purpose for undertaking Domestic Homicide Reviews (DHRs) is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.'[1]

1.4 The panel offer their sincere condolences to Anna's family and friends.

2. Timescales

2.1 On 15 January 2020, it was determined that the death of Anna met the criteria for a DHR.

2.2 The Home Office were notified of the decision to conduct a DHR on 15 January 2020.

2.3 The commissioning process for an independent Chair and the availability of the chair and panel members meant that the first meeting of the review panel did not take place until August 2020. The impact of the pandemic on agencies was significant at this time which resulted in senior staff members being unable to attend panel meetings. The DHR process was expedited as swiftly as possible, being conscious of agencies significant completing demands. Following this initial panel meeting, a further three meetings were held in October 2020, January 2021 and April 2021.

2.4 Following the last meeting in April, arrangements were made for the overview report to be translated into Polish, which is the first language of Anna's family. The family were then provided with the report and advised to take the time they

[1] Home Office Guidance Domestic Homicide Reviews, December 2016.

needed to review it. Following their initial review of the report, the family asked for some changes to be made to the report, which were then made.

2.5 The report was completed in February 2022, when the victim's family concluded they were happy with overview report.

2.6 The review was presented at a One Watford meeting on 08 March 2022. One Watford is the local strategic partnership (LSP) for the town and is chaired directly by the elected Mayor. It is made up of representatives from:

- Watford Borough Council
- Hertfordshire County Council
- Watford and Three Rivers Trust
- One YMCA
- West Hertfordshire Hospitals NHS Trust
- West Herts College
- Watford BID
- Watford Community Housing
- Job Centre Plus
- Watford Community Safety Partnership (Watford Police, Hertfordshire Police and Crime Commissioners Office, Hertfordshire Fire and Rescue, Probation Services)
- West Hertfordshire Primary Care Trust

2.7 Following a couple of minor changes being made to the report, as requested after presentation to One Watford, the review was submitted to the Home Office on 29 March 2022.

3. Confidentiality

3.1 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers

3.2 Pseudonyms for both the victim and the perpetrator have been used throughout this report to maintain anonymity. These pseudonyms were discussed with the family through their Victim Support case worker and were agreed. These are shown in the table below, which also provides an overview of the composition of the victim's family.

Pseudonym	**Age (at time of homicide)**	**Relationship to victim**	**Ethnicity**
Anna	49	Victim	White Polish
Tomasz	17	Victim's son and alleged perpetrator	White Polish
Jakub	52	Husband	White Polish

Piotr	29	Son	White Polish

3.3 The findings of agencies' Individual Management Reviews (IMRs) are confidential.[2] At the beginning of meetings of the review panel, attendees were asked to sign a confidentiality agreement. The information supplied throughout the review process was only available to those participating in the review and their line managers. All panel meetings took place over Microsoft Teams due to the Pandemic.

4. Terms of reference

In conducting the Domestic Homicide Review into the death of Anna, the Panel had regard to the following terms of reference.

4.1 Scope

4.1.1 This review was commissioned by Hertfordshire Domestic Abuse Partnership (HDAP) in partnership with Watford Community Safety Partnership as a result of the death of Anna in 2019.

4.1.2 The review focused on events from January 2017 until Anna's death. This date was chosen by the review panel because in January 2017, concerns were raised by Tomasz's school regarding his learning ability and a referral was made to an Educational Psychiatrist.

4.1.3 If it becomes apparent to the Chair that the timescale should be extended, this will be discussed with, and agreed by, the review panel. The chair of the Hertfordshire Domestic Abuse Partnership Board will then be informed.

4.2 Purpose

4.2.1 Community Safety Partnerships have a statutory duty to enquire about the death of a person in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9(3)(a). The Act states that a DHR should be a review:

> *…of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by a person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or a member of the same household as*

[2] The aim of the IMR is to: a) allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standards. b) identify how and when those changes or improvements will be brought about. c) identify examples of good practice within agencies.

themselves, held with a view to identifying the lessons learnt from the death.

4.2.2 The overall purpose of any DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

4.2.3 The purpose of this specific DHR is to:

- Gain an understanding of what pre-domestic abuse Anna suffered, if any.
- Establish the appropriateness of agency responses to Anna and her wider family, both historically and immediately prior to Anna's death.
- If and how agencies assessed risks within the family household.
- If and how agencies assessed needs for care and support within the household and care settings.
- Establish whether single agency and inter-agency responses to any concerns about Anna and Tomasz were appropriate.
- Identify any system issues and learnings within agencies.
- Identify good practice that was in place.
- Establish how well agencies worked together.
- Identify how inter-agency practice could be strengthened to improve the identification, and safeguarding, of vulnerable adults where domestic abuse is a feature.

4.2.4 The review will exclude consideration of who was culpable for the death.

4.3 Key Lines of Enquiry

4.3.1 **Information:**

- Did agencies comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

- Did agencies have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators, and were these assessments correctly used?

4.3.2 **Contact and support from agencies**

The Panel wish to determine:

- What disclosures were made to agencies and what were the circumstances behind them coming into contact with them?

- If and how did agencies assess risks to Anna?

- Were agencies' responses proportionate in relation to their knowledge?

- Did relevant agencies discharge their duties properly?

- What lessons are to be learned for the future?

- Was there any good practice demonstrated in agencies' interactions with Anna?

- Are agencies equipped to identify and respond to cases of domestic abuse where a child is abusing a parent? If so, was appropriate signposting and support available?

- How effective was inter-agency communication, including that between Children's Services and Adult Care Services?

- Did agencies encounter any difficulties when working with Anna and her family that had an impact on the case?

- Were the records kept by agencies accurate and up to date?

- Could any agency have acted differently during their involvement with Anna and other family members in a way that would have made a difference to the outcome?

- Did family members need support for possible substance misuse and mental health issues? If so, were these needs identified by agencies and were family members offered the appropriate support?

- Are Polish victims of domestic abuse less likely to be identified, and supported, by professionals?

- Are specialist domestic abuse services equally accessible to victims of domestic abuse whose first language is not English?

- Were there any other barriers to support in relation to communicating with professionals, including language and culture, religion?

4.3.3 If any additional information becomes available to inform the terms of reference of this review, this should be discussed and agreed by the chair and the review panel.

4.3.4 The panel shall also request access to any parallel reviews being conducted by individual agencies around their involvement with either Anna or Tomasz.

4.3.5 The Panel shall seek information on the background and any previous convictions of Tomasz and whether they had ever been subject to Multi Agency Public Protection (MAPPA) arrangements or perpetrator programs for perpetrators of domestic abuse

4.3.6 The overview report shall be written by the Chair, who will submit drafts to the review panel for their consideration. The report shall set out whether there are improvements that could be made in the way in which relevant agencies and organisations work individually or together to safeguard future potential victims.

4.3.7 The panel shall also consider whether further information should be made available in the public domain for the benefit of family or friends who have concerns relating to potential abusive relationships.

4.3.8 Subject to the point above, the panel will:

- Identify any changes in policies and procedures arising from the lessons learnt
- Make recommendations and identify actions
- Establish timescales for the implementation of an agreed action plan

5. Methodology

5.1 On 19 December 2019, Watford Community Safety Partnership and the Hertfordshire Domestic Abuse Partnership were notified of Anna's death by

Hertfordshire Constabulary. On 15 January 2020, it was determined that the criteria had been met for a DHR to be undertaken.

5.2 This decision was made by the Chair of Watford's Community Safety Partnership, the Chair of the Hertfordshire Domestic Abuse Partnership, the Chair of the DHR sub-group and a representative from the Strategic Partnerships Team at Hertfordshire Council, who are responsible for coordinating the delivery of Hertfordshire's Domestic Abuse Strategy.

5.3 The review panel determined which agencies were required to submit written information and in what format. Agencies with substantial contact were asked to produce Individual Management Reviews (IMRs).

5.4 One of the purposes of a DHR is to give an accurate as possible account of what originally transpired in an agency's response to Anna, to evaluate it fairly, and if necessary, to identify any improvements for future practice.

5.5 To that end, this report is based on relevant information obtained through agencies' IMRs and information from friends of both Anna and Tomasz. All IMRs were written by a professional who was independent from any involvement with the victim, family, friends, or the perpetrators. Should actions be necessary by any of the agencies, the maintenance, and strategic ownership, of any action plan will be the overall responsibility of Watford Community Safety Partnership.

5.6 Whilst key issues have been shared with organisations, the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Panel. To secure agreement, pre-publication drafts of this report are shared with the review panel, commissioning officers and members of the Community Safety Partnership. Individual IMRs will not be published.

6. Involvement of family, friends, work colleagues, neighbours, and wider community

6.1 The death of any person in circumstances such as those examined herein is a tragedy. The panel therefore send their sincere condolences to the family and friends of Anna and thank them for the time they have dedicated to ensuring Anna's voice can be heard in this report.

6.2 Family members and friends of both Anna and the Tomasz were notified by letter that a DHR was to be conducted. They were advised that they could contribute to the review in any way they felt comfortable. They were also provided with the

Home Office leaflet for families and were informed that they could be represented by a specialist advocate from AAFDA (Advocacy After Fatal Domestic Abuse). The offer of an advocate was declined.

6.3 A caseworker from Victim Support's Homicide Service was identified as working with family members and the Chair of this review made contact. The caseworker identified that family members did not wish to be a part of the review, but that they would like to be kept updated with the findings and recommendations from the review. The Chair therefore provided regular updates to the family through their Victim Support caseworker.

6.4 A Polish copy of the AAFDA information sheet was given to the family and they were also offered support from a Polish speaking advocate. At this point, they reiterated that they did not wish to participate and would just like to see a copy of the review upon completion. The family kindly provided the panel with a personal description of Anna and their loving thoughts of her. The family described Anna as being a wonderful mum, wife, daughter, and sister. She was family-orientated, and loved her family greatly, always providing food for daily meals. She particularly loved to eat nuts and waffles. Anna had a bubbly personality, was very friendly and hardworking - laughing and smiling often with family and work colleagues. Anna's husband stated that he was not aware of any problems between Anna and Tomasz and that he felt that they had a loving relationship. He never saw any instances of domestic abuse within the household and stated that if he had he would have intervened and asked for help. The report writer tried to contact the family through the Victim Support Officer upon receiving feedback from the Home Officer however, sadly they were unable to make any further contact. Anna's husband has returned to live in Poland and the eldest son has moved.

6.5 Family members were provided with a copy of the Terms of Reference, which were translated into Polish, and invited to contribute and comment. At the conclusion of the review process, Anna's family were contacted regarding reviewing the overview report and its recommendations and speaking to the Chair. The overview report was translated into Polish and was provided to the family through their Victim Support caseworker.

6.6 Identified friends of both Anna and Tomasz were spoken to by the Chair and Report writer and provided information into the family dynamics. The panel would like to extend their thanks for their time.

6.7 The overview report was shared with Anna's husband and son prior to being submitted to the Home Office. The family suggested amendments to the report,

which have been accepted by the Chair and incorporated into the report. The family also wrote a response to the report, which is attached as Appendix A. The independent chair and the panel would like to sincerely thank family members for all their time and support in such difficult circumstances and for their comments. Thanks also go to Victim Support for their excellent work in supporting the family through this process.

6.8 The Chair spoke to the Senior Investigating Officer, who felt that it was not appropriate for Tomasz to be interviewed until after he had been sentenced. After the sentencing, the Chair spoke to Tomasz's social worker and requested an interview with Tomasz. This was declined by Tomasz.

7. Contributors to the review

7.1 Scoping letters were sent out to:

- GP services
- Hertfordshire Constabulary
- Hertfordshire County Council's Children's Services and Adult Care Services
- Watford Borough Council
- Refuge (who provide the Hertfordshire IDVA service)
- Hertfordshire Partnership Foundation Trust (the county's provider of mental health services)
- National Probation Services
- Bedfordshire, Northamptonshire, Cambridgeshire & Hertfordshire (BeNCH) Community Rehabilitation Company
- Citizens Advice Bureau

7.2 As a result of the information received, these agencies were asked to submit chronologies.

7.3 Individual Management Reviews (IMRs) were requested from Community Housing and Youth Connections Hertfordshire. The IMRs were quality assured by supervisor's and were signed off by management prior to being presented to the panel

7.4 All other agencies were asked to identify significant information that either raised concerns or indicated good practice.

7.5 The Youth Connections Hertfordshire Services for Young People (SfYP) IMR was completed by Deborah Barker, SfYP Policy and Practice Manager. The Community Housing IMR was completed by Amy Willcox-Smith, Head of

Customer Relationships. Both IMR writers identified that they were independent of the case and did not line manage any individual who had contact with the family.

8. The Review Panel Members

8.1 The names of DHR panel members and their role, job title and the agency they represent are detailed in the table below.

8.2 The panel met on four occasions between August 2020 and April 2021.

8.3 All panel members were independent of any line management of staff involved in the case.

Name	Position and Organisation
Elizabeth Hanlon	Independent Chair and Report Writer
Danielle Davis	Senior Development Manager, Adult Care Services, Hertfordshire County Council
Tracey Cooper	Associate Director Adult Safeguarding, East and North Herts and Herts Valleys Clinical Commissioning Groups
Alan Gough	Group Head of Community and Environmental Services, Borough Council
Saira Awan	General Practitioner
Graeme Walsingham	Detective Chief Inspector, Hertfordshire Constabulary
Janet Jones	Head of Assessments, Children's Services
Maria Sharples	Community Housing Trust

Amy Willcox-Smith	Head of Customer Relationships, Watford Community Housing Trust
Karen Hastings	Consultant Social Worker (Adult Safeguarding)/AMHP, Hertfordshire Partnership Foundation NHS Trust
Jonathan Jack	Services for Young Persons, SfYP, Strategy and Development Manager, Children's Services
Julia Dwyer	Senior Operations Manager, Refuge
Julia Kulak	Service Manager -Refuge, Eastern European Independent Gender Violence Advocacy Service. EE IGVA
Louise Coulson	Senior Operations Manager, Refuge
Vicky Boxer	Senior Social Worker and Safeguarding Lead, Spectrum Change, Grow, Live (CGL)

9. Author of the overview report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016, sets out the requirements for review chairs and authors. In this case, the chair and author were one individual.

9.2 The independent chair and report writer appointed by the Watford Community Safety Partnership was Elizabeth Hanlon, who is independent of the Community Safety Partnership and all agencies associated with this overview report.

9.3 Elizabeth Hanlon is the current independent chair for the Hertfordshire Safeguarding Adults Board. This is an independent role and as such, she has no affiliation to any of the agencies involved in the review. The role of the chair of the Safeguarding Adults Board is to gain assurance that agencies are safeguarding adults with care and support needs within Hertfordshire and to hold these agencies to account. As such, the chair must remain independent on all occasions and must act as an independent scrutineer.

9.4 Elizabeth Hanlon is also a retired senior police detective from Hertfordshire Constabulary, having retired in 2015. She has several years' experience of partnership working and involvement with several previous Domestic Homicide Reviews, Partnership Reviews and Serious Case Reviews in Hertfordshire. She has also completed several DHRs for Cambridgeshire and Essex County Councils.

9.5 Elizabeth Hanlon has received training in the writing of DHRs and has completed the Home Office online training and online seminars. She also attends the yearly Domestic Abuse conferences held in Hertfordshire and holds regular meetings with the chair of the Domestic Abuse Partnership Board in Hertfordshire to share learning.

10. Parallel Reviews

10.1 In early November 2020, following a criminal trial at St Albans Crown Court, Tomasz was convicted of the murder of Anna and received a life sentence and ordered to serve a minimum of a minimum term of 13 years.

10.2 No other reviews were conducted in parallel with this DHR.

11. Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protective characteristics as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

11.2 The Panel considered the nine protected Characteristics under the Equality Act 2010. They sought to establish which had relevance in terms of provision of services by agencies or had in any way acted as a barrier. Those identified as relevant are outlined below.

11.3 Race

11.3.1 In the Equalities Act (2010), race refers to the protected characteristic of race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.

11.3.2 Anna was a white female of Polish nationality, aged 49 at the time of her death.

11.3.3 The perpetrator, Tomasz, is the victim's son and a white male aged 17 years at the time of the murder. He is also a Polish National.

11.3.4 Tomasz's father, Jakub, came to England in 2005 and moved to their current address in 2006, at which point he was then joined by the rest of the family. Tomasz would have been 4 years old at this time. Anna and Jakub also have an older son, Piotr.

11.3.5 Anna and Jakub were both described as speaking very little English. They had to bring one of their children with them to act as interpreters if they needed support.

11.3.6 Both of Anna and Jakub's children, Tomasz, and Piotr, spoke English and Tomasz had gone to an English-speaking school. The panel identified that all contact with, and correspondence to, Anna and Jakub were in English and that very little consideration was given to the family regarding them being Polish nationals living in England with little family support. There is greater reflection on this later in this report.

11.3.7 Vesta[3] identifies that domestic abuse remains to be a hidden problem in the Polish community. Through their previous work in the Polish Domestic Violence Helpline, they have identified that most families affected by abuse are not known to their local agencies and that victims face a lot of barriers in reporting domestic abuse and seeking help. Vesta report that domestic violence in Polish families can be dangerous, and that almost half of the women who contacted their help line were at a high risk of serious harm or even death[4].

11.4 Sex

11.4.1 There are large differences in the profile of victim-suspect relationships between male and females. In the year ending March 2021, female victims were more commonly killed by a partner or ex-partner or a family member. There were 114 domestic homicides in the year ending March 2021, of those 114 domestic homicides, 67 victims were killed by a partner or ex-partner, 27 were killed by a parent, son or daughter and 20 were killed by another family member. Almost half of adult female homicide victims were killed in a domestic homicide[5].

[3] Vesta offers family support for Polish Nationals in England and Wales.
[4] Vesta SFS | Domestic violence support for Polish victims and perpetrators
[5] Office for National Statistic, Homicide in England and Wales: year ending March 2021 *ons.gov.uk*

11.4.2 In a recent review of 21 cases of parricide, conducted as part of a research project into the issue, the following perpetrator characteristics were identified:

- In 14 cases, the offender was the biological offspring of the victim
- In 15 cases, the perpetrator was male
- In 2 cases, the perpetrators were female.[6]

11.4.3 In contrast, parricide victims were identified as being mainly female, with 12 being female and 5 being male.

11.4.4 This, and other research, shows that fatal violence is gender based, and that women are the main victims of abuse and homicide both by intimate partners and their children.

11.4.5 Finally, the research into parricide also identified that the average age of female victims was between 43 and 86, and that older victims (those over 58), were just as likely to be murdered by an intimate partner as a child. Most of the victims and perpetrators were identified as being non white British.

12. Dissemination

12.1 The Panel shall, once it has agreed the final report, submit it to Watford Community Safety Partnership, who will consider the content of the report, the recommendations, and the associated action plan. If they are satisfied with the report, it shall be requested to submit the report to the Home Office.

12.2 The overall report will be published on the website of Watford Borough Council. Family members will be provided with the website address and offered hard copies of the report. The Strategic Domestic Abuse Partnership Board will disseminate the report to all members of the Board and learning events take place throughout the year where findings from reviews are highlighted. The report will also be published on the Hertfordshire Sunflower Website.

12.3 Circulation is restricted to staff directly involved in the review and the managers within the following organisations:

- Community Safety Partnership.
- Hertfordshire Domestic Abuse Strategic Partnership.
- Hertfordshire County Council.
- Hertfordshire Constabulary.
- District Council.

[6]*: Holt, A. (2017). Parricide in England and Wales (1977–2012): An exploration of offenders, victims, incidents and outcomes. Criminology & Criminal Justice*

- Hertfordshire Partnership University NHS Foundation Trust.
- Herts Valleys West Hertfordshire, Clinical Commissioning Groups.
- Refuge (providers of Hertfordshire IDVA Service).
- West Hertfordshire NHS Trust.
- Police and Crime Commissioner
- Director of Adult Care, Hertfordshire

12.4 In accordance with Home Office guidance, all agencies and the family and friends of Anna and Tomasz are aware that the final overview report will be published.

12.5 IMR reports will not be made publicly available, although any key issues identified will be shared with specific organisations.

12.6 The overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Panel.

12.7 The content of the overview report has been suitably anonymised to protect the identity of the victim and her family and friends. The overview report will be produced in a format that is suitable for publication with any suggested redactions before publication.

13. Background information (the facts)

13.1 Police were called by the ambulance service to an address in December 2019 following a 999 call to them by Tomasz, who was identified as being aged 17 years.

13.2 He reported to ambulance control that his mother, Anna, had stabbed herself at their home address. Upon arrival of the ambulance service, he disclosed that he had returned from a job interview at 3pm that afternoon and that his mother had returned home some 20 minutes later. He said that she called him down from upstairs and proceeded to stab herself with a kitchen knife.

13.3 There were indications that Anna had been dragged from one room to another, and that efforts had been made to clean blood from the floor. Anna appeared to be suffering from multiple stab wounds. A large kitchen knife was close by, which appeared to belong to a block set from the kitchen of the premises. There was no apparent forced entry.

13.4 Paramedics confirmed the presence of rigor mortis, casting further doubt on Tomasz's account. He was arrested on suspicion of the murder of his mother.

13.5 Tomasz was subject to a mental health assessment in custody but was deemed fit and well for detention and interview. Tomasz was charged and remanded for the murder of Anna.

13.6 A post-mortem examination revealed the cause of death to be multiple stab wounds to the neck, abdomen, and chest areas.

13.7 At this time, the family did not know the motive for the murder. Tomasz proceeded to give a no comment interview.

13.8 The police spoke to Anna's husband, Jakub, who explained that Anna was a heavy drinker and often slept in a different room to him. The family identified to the police that Anna had had drink related problems in Poland and that she had spent money set aside for Christmas on alcohol. It appears that a family member had taken Anna to an Alcohol Anonymous (AA) meeting at one point, but that she hadn't wanted to go back. The fact that she used to drink apparently caused arguments within the family, although there was no explicit mention of domestic abuse. There was no indication from the family of any previous mental health or behavioural issues surrounding Tomasz.

13.9 Tomasz was found guilty of the murder of his mother and was given a life sentence in November 2020. The verdict of the inquest was open and closed due to Anna's death being recorded as murder. Anna's death is recorded as resulting from numerous stab wounds

14. Chronology

14.1 This section of the report provides background detail of Anna and Tomasz taken from information provided by professionals. It provides context of the dynamics of the relationship between Anna and Tomasz and a chronology of contact with professionals.

2008

14.2 In 2008, a housing application was submitted to Watford Community Housing Trust (WCHT) by Jakub and a subsequent tenancy was offered. Anna was not offered a joint tenancy but was part of the household application.

14.3 There are numerous reports of contact being made by WCHT to Jakub regarding non-payment of rent, eviction notices and benefit awards.

14.4 It is recorded that WCHT were aware the family were Polish nationals and that both Jakub and Anna spoke only very limited English, using their children as interpreters. This is highlighted here, as it does not appear that agencies

considered the possibility of arranging personal visits with interpreters or translating the letters that were sent to the family into Polish.

2012

14.5 A referral was made to an Educational Psychologist by the school, for Tomasz, in 2012. A full assessment of needs was carried out and the Educational Psychologist stated that:

> *'This assessment indicates that Tomasz has significant cognitive difficulties, which are likely to impact on his learning achievements. Tomasz's learning difficulties are such that his access to the National Curriculum is likely to be severely restricted.'*

2017

14.6 In January 2017, a Notice of Seeking Possession letter was sent to Jakub at their home address. The letter was advising Jakub of rent arrears. There is no record of any further contact with the family or follow up for several months. It is not known how this was resolved.

14.7 In July 2017, when in Year 10, Tomasz was visited in school by a SfYP Personal Adviser for career guidance intervention, which took place regarding his future. The County Council's SfYP provides youth work projects, information, advice, guidance, work-related learning, and wider support for young people in Hertfordshire.

14.8 The visit took place as part of the Risk Assessment Planning Process. This process was initiated by the school because Tomasz had been identified as being unlikely to achieve 5 GCSEs at grade C. At that point, Tomasz was in the final term of year 10 and stated that he enjoyed history and geography. An action plan was drafted to help Tomasz consider his next steps.

14.9 In November 2017, when in Year 11, Tomasz was visited at school by the same Personal Adviser from SfYP to continue discussions regarding his future. Tomasz was encouraged to attend open days to explore his options further.

2018

14.10 In February 2018, Anna attended her GP surgery for a health check with a nurse. It is recorded that she attended with her son, who acted as an interpreter. It is not recorded which son attended with her, but it is believed to be Piotr.

14.11 Anna's alcohol intake was discussed, and she identified that she would like support to stop smoking. Anna was advised to make an appointment for a smoking cessation clinic, but it does not appear that an appointment was made.

14.12 In July 2018, a follow up call was made to Tomasz by SfYP. He confirmed that he had been offered a place at a college on both their Level 2 Travel and Tourism course and the Level 3 Graphic Design course. He accepted the Travel and Tourism course.

2019

14.13 In September 2019, a letter was sent to Jakub from the Community Housing Provider (CHP) where a Notice of Seeking Possession of his property was issued. A week later, a follow up text message was sent advising of arrears and that regular payments were not being made. Two further text messages were sent in September, also advising of arrears and non-payment, and requesting contact.

14.14 The housing department identified within their IMR that Jakub was often served with a Notice of Seeking Possession due to regular non-payment of rent. The purpose of the notice was to encourage Jakub to make contact. The housing department confirmed that support agencies are listed within their notices. However, the Notice sent was in English and consideration was not given to translating the document into Polish.

14.15 In October 2019, as part of the annual destination survey, and because contact had not been possible by phone, a member of the SfYP outreach team called at Tomasz's home address. No one was available, so an outreach pack was left with details of how to contact SfYP for further support.

14.16 A further text message was sent to Jakub regarding rent arrears and non-payment. A housing officer then attended the property and spoke to Jakub. A window in the side door kitchen glass was reported to need replacing. Jakub stated that the window had broken during a storm. The outside toilet was also reported as not working. Officers checked the property and the rooms and no further issues with the condition of the property were identified.

14.17 According to the Neighbourhood Officer, the household were relaxed, and were in their pyjamas or loungewear on attendance. When questioned about support services they were engaged with, they were said "no - none required".

14.18 It was noted that Jakub spoke limited English and could not confirm dates of birth, as he did not understand the request, and he had no household ID to hand. Tomasz was present and did some informal brief translation. Anna was not present during the visit but was reported as still living there. The Community Housing Department identified that they could have considered using an

interpreting service but had noted within their report that Jakub appeared comfortable with Tomasz interpreting for him.

14.19 In November 2019, a second outreach visit was completed by the SfYP service. This was following several unanswered calls to Tomasz. Tomasz was home and spoke to the Personal Adviser. Tomasz advised that he had missed the college application deadline for the Travel and Tourism course at West Herts College. It was established that he needed support to find an alternative route or employment. Tomasz agreed to attend the Young People's Centre for support.

14.20 Ten days later, Tomasz attended the SfYP for employment support and met with a Personal Adviser. Tomasz explained that he had struggled with the Travel and Tourism course and wasn't invited back to complete Level 2. He now wanted to focus on finding full-time employment in a “simple, local job”. He looked at several opportunities with the Personal Adviser and agreed to apply for them. It was identified that Tomasz could benefit with some additional Personal Adviser support.

14.21 Tomasz was telephoned by his allocated Employment and Training Adviser (ETA) but there was no answer. She subsequently texted him to introduce herself as the new point of contact for future job searches and to make an appointment. Tomasz attended YPC and was supported to apply for three jobs. An additional appointment was offered to Tomasz for the following week to get support with improving his CV.

14.22 In December 2019, Tomasz texted expressing interest in a job match and was provided with further information. The next day, Tomasz attended an appointment with his ETA, updated his CV and applied for six jobs with her help. She asked to make another appointment with him, but he said he would let her know. Tomasz texted with interest in another vacancy and was again provided with further information.

14.23 A letter was sent to Jakub from the housing department to advise him that the rent account had not been cleared.

14.24 A call was received by the emergency services from Anna and Tomasz’s home address by a male who identified himself as Tomasz stating that his mother has stabbed herself and was unconscious and bleeding. The ambulance service and police attended the address where they found Anna with numerous stab wounds. These wounds did not appear to be consistent with the account given by Tomasz, which was that Anna had stabbed herself, and Tomasz was subsequently arrested on suspicion of her murder.

15. Overview

15.1 The Community Housing Provider (CHP)

15.1.1 The CHP identified that they currently have 84 Polish tenants within their area, and they also have several Polish staff working for them. They identified that they did not have a disproportionate level of involvement with the Polish community in any way and had good established links with the local Polish school and a local Polish radio station, who they had worked with previously.

15.1.2 It seems the family were consistently in rental arrears, and there were multiple letters of intended eviction and threatened court cases in the several years leading to Anna's death. During that time, there is no mention of any additional support being given to the family.

15.1.3 The CHP have identified a single agency recommendation surrounding the support available to their tenants and how this support is available and accessible:

- The CHP is to have sessions with their income team to discuss ways to offer support.

- The CHP is to carry out an investigation of cases of concern and to look at arrear's methodology.

15.1.4 The CHP had no direct contact with Anna, as she was not on the tenancy agreement. They had one interaction with Tomasz, who acted as an interpreter for his father following a visit to the property. They have identified in their IMR that communications could have been better with Jakob. However, they stated that he appeared happy to use his son as a translator on the one occasion that they spoke to him. The CHP have identified that translation services should be more widely encouraged, even if family members offer to translate. They are currently creating a bespoke communication that can be handed out to customers during visits. This will be in the form of a card that can be posted offering support and help. They are also looking at ways to better promote and understand the amount of people using their website and the Google translate function.

15.1.5 The CHP have also identified the following recommendation following their review:

- To review the offer of their translation services, including the creating of a calling card for NOSP letters and for officers to use whilst 'on patch'.

15.1.6 In October 2019, when housing officers attended the home address, family members were asked about the damage to the kitchen window and how it had happened. It was identified that the damage had been caused during a storm. This was an opportunity to identify the dynamics within the family and to identify whether there were any causes for concern or the need for intervention.

15.1.7 The CHP were not aware of any instances of domestic abuse within the household. Since Anna's death, they have reviewed their policies and procedures relating to the way they manage tenancies and support vulnerable people, including victims of domestic abuse. These policies were identified as being up to date and fit for purpose. Staff receive the appropriate training.

15.1.8 Since the death of Anna, CHP have conducted an in-depth review of several their cases of concern, who are in rent arrears, to see if there is anything that can be done differently in terms of communication. They are also working with Watford Borough Council to examine at groups most at risk of domestic abuse in their properties. They will also conduct a joint communication campaign and educate staff of the signs of domestic abuse and risk factors. More visits will also be completed to homes where there is no contact with the tenant.

15.1.9 The following recommendation has therefore also been made by CHP:

- To explore and implement community projects which support victims of domestic abuse following the outcome of the review.

15.2 YC Hertfordshire Services for Young People (SfYP)

15.2.1 YC Hertfordshire SfYP provides targeted youth work, information, advice, careers guidance and work-related learning to young people aged 11-17 (up to 24 for those with special educational needs and disabilities). It helps young people to develop personal and social skills and resilience, supporting progression and economic independence. The service delivers targeted prevention and early intervention work using the professional practice of informal education, addressing emerging needs, improving life chances, and reducing escalation to more expensive and intensive services.

15.2.2 At school, Tomasz was referred to a SfYP Personal Adviser (PA), as part of a paid for contract, when the school had determined he would be unlikely to achieve 5 GCSEs. The PA was contracted to provide advice about potential education, training, and career opportunities.

15.2.3 The very first involvement with Tomasz occurred in school. There are no records of any information that may have been passed from the school to the SfYP PA. It does appear that both conversations at school were based solely on determining Tomasz's needs for education, training, and career support. There does not appear to have been any probing conversations with Tomasz regarding his family

background or looking into the possible reasons behind his low educational attainment. Had these conversations taken place, the support worker may have deemed Tomasz as being suitable for additional support. SfYP have reviewed their policies because of this review. During the review the family identified that they felt that contact with Tomasz's school was poor, and they were not aware of any significant problems being identified by the school. They felt that they had limited interaction with the school and were not spoken to regarding Tomasz's behaviour or concerns identified about him personally only educationally wise. It was identified that any concerns that they school might have had in relation to Tomasz's behaviour were not communicated to the family and as such this was a missed opportunity to engage better.

15.2.4 Once Tomasz had left school, routine follow-ups (by phone) took place as part of the 'September Guarantee' process, confirming that he had been offered a place at college. This is the usual process SfYP follows, in which all young people not known to be in education are contacted for information, per the County Council's statutory duty.

15.2.5 A year passed between confirmation of Tomasz's college place and the next attempted contact by SfYP, at which point Tomasz was counted as a 'lost contact.' Lost contacts are passed to the Keeping in Touch team (KIT), who attempt to ascertain the young person's status as part of the County Council's statutory duty to decrease the rate of NEETs (Not in Education, Employment or Training). It appears that the KIT team made every endeavor to re-engage with Tomasz by phone and text, even calling a second mobile number thought to belong to his father and ensured that his address was provided to the outreach team for further action.

15.2.6 Tomasz was caught, by chance, at his home address during a second outreach visit. It is at this point that Tomasz confirmed that he did not start the second year of college. There was no engagement with the college by SfYP as it is not considered within general practice guidelines to do so, with interactions being between the SfYP practitioner and young person only.

15.2.7 It is not clear how much of the college course Tomasz completed or why he left, but this information could have helped SfYP understand Tomasz's reasons for dropping out. It may have also prompted a Contextual Safeguarding approach. Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhood, schools and online can feature violence and abuse. Parents and

carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.[7]

15.2.8 SfYP have identified a single agency recommendation in relation to staff training. The recommendation seeks to ensure that all SfYP practitioners have direct interactions with young people, use their professional curiosity to identify and understand indicators of abuse and the impact that these could have on the young person's behaviour, education, and aspirations. The recommendation is as follows:

- Training to understand the concept of contextual safeguarding and relevant support mechanisms.

15.2.9 Tomasz's reasons for leaving college were not probed by the practitioners dealing with Tomasz from this point onwards. The main reason cited for not contacting the college was that the service focuses solely on the young person's needs in the context of careers and education advice. Data protection, and a lack of information sharing agreements, were also cited as inhibitors to seeking (and providing) information from third party organisations. The practitioner, when interviewed as part of this review, said that with hindsight, Tomasz did appear to be 'drifting' and was not highly motivated to engage. During the interviews with Tomasz, he presented as a nice, polite young man who was a little shy. Tomasz told the support worker that he enjoyed cooking and cleaning in the family home and would like to develop a career in catering.

15.2.10 Both practitioners interviewed felt that language was not a barrier for Tomasz, who had a very good command of spoken English. The practitioners noted that Tomasz had changed his mind several times about the direction of his future but felt this to be quite normal in this particular cohort of young people struggling to achieve the Government's educational standard. The agency's IMR identified the number of missed and unreturned calls made to Tomasz as concerning and something that might have raised questions with professionals.

15.2.11 SfYP identified a further recommendation for their agency regarding lack of contact with Tomasz. The recommendations below seek to ensure that processes are developed that will help to identify potential young people (lost contacts) who may fall through the gaps for support.

- Development of a 'flag' system for the KIT team, for when a young person has been particularly difficult to contact.

- Process to be developed for follow up with school, parent, college, or workplace when a young person reaches the 'flagged' stage.

[7] https://www.contextualsafeguarding.org.uk/

15.3 Family and friends

15.3.1 Anna's family described Anna and Tomasz as having a good relationship and that they didn't fight or argue and that the murder had come out of the blue for them. Anna's husband described Anna as being his best friend. The eldest Son stated that his mother was a different person when she drunk and that she would shout at him and his father but that she would never shout at Tomasz. He said that these drinking arguments usually occurred every month. He said that his mother was a good wife and mother and that she worked hard and got on well with everyone. She enjoyed being a mother. The family described Anna as having colleagues at work but that the family had no other family members in the UK, and not many other friends.

15.3.2 The Chair spoke to a work colleague of Anna's, who stated that although they were friends at work, they did not socialise outside work. She described Anna as being a lovely person who was very hard working. They worked together as cleaners and Anna always appeared to be happy. She stated that Anna didn't speak about her family much, but that she knew she was married with children. She did state that she would often be able to smell alcohol on Anna's breath but that she never appeared to be drunk or to drink whilst she was at work. Anna's friend stated that Anna did not mention any problems at home and that there was no indication of domestic abuse within the family. She did day however, that she did not feel that herself and Anna were close enough in friendship for her to confide in her if there were any issues at home. She identified being aware that domestic abuse took place within families but did not feel that this was a factor in Anna's life.

15.3.3 A friend of Tomasz's was also spoken to. He described Tomasz and himself as being friends from school and college. He stated that they first met when Tomasz started school, and that they then used to eat lunch and walk home together. Tomasz's friend stated that he was being bullied at school and that Tomasz had stepped in and helped him out, which is how they had become friends. He said that Tomasz was a good friend to him.

15.3.4 He described Tomasz as being quiet and shy at school, and that he didn't have many friends there. However, he did have Polish friends outside of school. He believed that Tomasz had a close relationship with his mother and that she used to meet him halfway when they were walking home, and she would walk with them. Tomasz had told him that he didn't have a good relationship with his father and that his father would often shout and swear at him. On one occasion, Tomasz had asked him if he could come and live with him as he wanted to move out of the family home. He said that Tomasz had told him that his dad was going to kick him out. He believed that there was friction in the house due to Tomasz not working.

15.3.5 The friend said that Tomasz would often come to his house but that he didn't often go to Tomasz's. He said on one occasion when he did go to Tomasz's home, Tomasz made him stand on the doorstep and wouldn't invite him in. He stated that the main form of communication outside school was via text message, as Tomasz didn't like to answer the phone.

15.3.6 Tomasz's friend described how Tomasz had a fascination with guns and that when they were at school, Tomasz would talk about guns all the time. He knew a great deal about them and studied them and could tell people different facts about different guns. He described how Tomasz had gotten into trouble at school as he had printed off pictures of guns which he had found on the internet. He believed that Tomasz's parents were contacted about it. The family identified that as a hobby they have an interest in military memorabilia and they have an air weapon and deactivated firearm within the household. The air weapon was used by the father in the garden for target practice and this sort of activity is not unusual in Poland.

15.3.7 Tomasz's friend stated that he last saw him in October 2019, but that he didn't have any concerns about him because Tomasz's behaviour hadn't changed in any way. He knew that he was looking for a job. He did state, however, that Tomasz's personal hygiene wasn't very good and that he smelt when he met him as if he hadn't had a shower for a while. He described being very shocked at the death of Tomasz's mother and that Tomasz had been responsible. Tomasz's friend stated that he was not aware of any issues of domestic abuse taking place within the family and that Tomasz never spoke of being unhappy with his mother nor identified any concerns.

16. Analysis

16.1 Experiences of domestic abuse for European nationals in Hertfordshire

16.1.1 Data supplied from the Annual Population Survey 2019-2020, which is comprised of the Labour Force Survey and sample boosts in England, Wales and Scotland shows that the two greatest foreign nationalities registered as living in Hertfordshire are those of Polish or Romanian nationality.[8] The panel therefore wanted to gain a fuller understanding of Polish communities in Hertfordshire, how best they can work with them and how to offer the most appropriate help and support.

16.1.2 As such, the DHR panel were lucky to have two members of Refuge, one of whom is the service manager for Refuge's Eastern European Independent Gender Violence Advocacy Service and is herself a Polish national. The Refuge Eastern

[8] Population of the UK by country of birth and nationality: individual country data

European service manager kindly presented to the panel her thoughts and views in supporting Polish nationals who are survivors of domestic abuse, including the barriers to support that they experience.

16.1.3 The EE IGVA Service Manager has extensive experience in supporting Eastern European survivors, having joined the Eastern European Advocacy Service as a Polish speaking worker in October 2015. In March 2016, she became the manager of the service. Working as an IDVA and manager of the Eastern European Advocacy Service has allowed the panel to make use of her understanding of Eastern European cultures, religion, and language.

16.1.4 The EE IGVA Service Manager described to the panel how Polish women often feel that they have to be the perfect wife, housewife and mother and that women in the family are often blamed for any challenges that might occur, including problems with children, mental health issues and alcohol or drug abuse.

16.1.5 The EE IGVA Service Manager also described language as being one of the main barriers for nationals who have moved to live in England from other countries. She stated that a large majority of people do not speak or understand English enough to be able to fully comprehend what is being explained to them, or to be able to answer specific questions.

16.1.6 They also heavily rely on younger family members to interpret for them, as they have often been through the English educational system and are therefore more able to understand and communicate. This, in turn, can mean that parents wishing to disclose domestic abuse feel they cannot do so, as they do not want their children or other members of their family to be made aware.

16.1.7 Anna attended her GP surgery for a health check with a nurse. It is recorded that she attended with her son, who acted as an interpreter. It is not recorded which son attended with her, but it is believed to be Piotr. During the heath check Anna's alcohol intake was discussed and it was during this consultation that she requested help to stop smoking. Anna did not disclose to the nurse any alcohol intake problems but stated that she would like to receive help in stopping smoking. Anna does not appear to have been asked any questions regarding her home life or domestic abuse within the household although there were no tiggers identified during the health check that would have warranted further exploitation.

16.1.8 This raises a question as to whether Anna would have disclosed domestic abuse if her son were present and acting as an interpreter. Having a family member act as an interpreter severely restricts someone's opportunity to disclose abuse or to ask for help and support.

16.1.9 The panel discussed how open Anna would have been with professionals if she was having to discuss personal things in front of her son. This might be why Anna did not make a follow up appointment.

16.1.10 A representative from the GP surgery stated, during panel meetings, that they do have access to an interpreter service and that they would arrange an interpreter if the appointment were booked in advance, and they were aware of a patient needing one. The representative stated that family members and friends are often used as interpreters if appointments are made at the last minute and there is no time to arrange the service. In these cases, consent is always gained by the person having the appointment to use their family member as an interpreter.

16.1.11 It is important to note, at this point, non-English speakers living in the UK do not always have the support from other family members, meaning they are more reliant on professionals for support.

16.1.12 NHS England published guidance in September 2018 on commissioning interpretation and translation services in primary care.[9] The guidance states that the NHS is committed to providing high quality, equitable, effective healthcare services that are responsive to all patients' needs.

16.1.13 It was however, identified that there are often significant delays in accessing services due to a lack of translators and therefore parents rely very heavily on their children to translate for them. This can be the cause of confusion as children do not always understand what is happening or appreciate the importance of what is being said to them.

16.1.14 The EE IGVA Service Manager stated that in Poland, the police are often very 'dismissive' of domestic abuse, seeing it more as a family or personal matter that they won't get involved with. Many Eastern Europeans in the UK believe that police in the UK will respond to domestic abuse in the same way, and therefore will be reluctant to report domestic abuse. A common belief amongst Polish people in the UK is that it is their individual responsibility to push cases of domestic abuse through the court system, including paying for a solicitor. It was identified that Anna was unlikely to have access to information about domestic abuse or other support agencies for mental health or substance abuse.

16.1.15 The EE IGVA Service Manager also identified barriers surrounding agencies involvement with families who had children. She stated that many Eastern European nationals believe that if agencies become involved with a family, then

[9] Guidance for commissioners: Interpreting and Translation Services in Primary Care 2018

the children will be taken away. She highlighted the fact that there are still newspaper articles in Eastern European countries reiterating how children will be removed if agencies became involved.

16.1.16 The EE IGVA also spoke of how the Polish community often like to keep to themselves, and do not like others to know there are problems within their family. It can be rare for them to access support due to concerns about shame and stigma.

16.2 The impact of Brexit

16.2.1 The impact of Brexit on Eastern Europeans in the UK was also identified. Many Eastern Europeans now believe they are no longer entitled to the support that was available to them before Brexit. They are also sometimes fearful that their need for additional support, especially in terms of finding and accessing services, will be held against them and that they would somehow be punished.

16.2.2 Information regarding Brexit in the public domain was identified as being very misleading and has raised several concerns within the Eastern European community. Some nationals believe that since Brexit, they are now unable to access certain stores, such as Tesco, due to them being British.

16.2.3 Concerns were also raised regarding information available about recourse to public funds and the impact that Brexit would have on access to benefits. There is still uncertainty around what services and support foreign nationals can access, which has only been intensified by Brexit. The panel felt this would further isolate victims of domestic abuse.

16.3 Additional barriers

16.3.1 Anna's use of alcohol and any barriers to obtaining support she may have encountered were also discussed during this review. The EE IGVA Service Manager described substance misuse in Eastern European countries as being more acceptable than in Britain. Drinking alcohol is much more accepted and is embedded in Polish life and community. Alcohol addiction is much less recognised, and there is a social belief that as long as you can function, excess alcohol consumption is acceptable.

16.3.2 Anna's stated that the family had taken Anna to two AA meetings which she had attended with her eldest son. Anna's son attended on a couple of occasions to help Anna find her way to the meetings and to help her settle in. Anna continued to attend on her own a couple of times but then stopped stating that she did not like the meetings. Anna did, however, stop drinking between March and November of that year. Anna's eldest son stated that they believed that Anna could have a drink at her 50th birthday but after that she had stated drinking again. The AA meetings were researched by Anna's husband as he was

concerned about her drinking. The AA meetings were attended by people who spoke Polish. The AA do hold 'open meetings' where members are allowed to attend with family members. The AA provide contact details for Polish nationals who live in England and wish to attend Polish speaking meetings. Access to these meetings is through their website and there are Polish speaking AA meetings in several locations in Hertfordshire.

16.3.3 Possible stigma around mental health issues were also discussed. The EE IGVA stated that mental health problems are often minimised in Poland due to stigma. Polish families often worry that they will be judged if it is identified that either the parents or children within a family had any mental health issues. There is also stigma around accessing support services, unless it is considered there is no alternative.

16.4 Parricide: children who murder their parents

16.4.1 Parricide is the term used to describe to the killing of one's own parents. Matricide refers to the killing of one's mother. In the UK, it is thought that there are around nine cases of parricide per year. Research carried out indicates that most offenders are adults and are over the age of 18 years at the time of the murder. However, one in five parricides are carried out by offenders under the age of 18 years, with 30% of those being under the age of 20 years.[10]

16.4.2 Recent research by Dr Heide has highlighted the key differences between adolescents who commit parricide and adults. Adolescents are more likely to commit parricide when their home life is problematic. The reasons cited for this are:

- They cannot simply leave as they have nowhere to go
- They have no money
- They have not completed education, meaning it is difficult to get a job and provide for themselves.

16.4.3 Adolescents are also still developing. They have less life experience and less understanding of their own emotions compared to adults, and therefore are less able to deal with difficult situations and conflict. Adolescents are, according to this research, less likely to think about the consequences of their actions or to consider alternative options available to them. They often cannot weigh up decisions in the same way that adults can.[11]

[3] Fiona Guy, *Family Violence and Homicide* July 2018.
[11] Kathleen M. Heide, '*Understanding Parricide: When Sons and Daughters Kill Parents*', 2013

16.4.4 Another study conducted by Dr Heide found that adolescences who commit parricide often have parents who have not been available to help them. In fact, they are most often assuming the responsibility of an adult within their families.

16.4.5 During the investigation into Anna's death, the police forensically examined Tomasz's phone and computer. During this examination, they found that Tomasz had conducted extensive internet searches a month before Anna's death about:

- Ways to buy a gun
- How to poison someone
- How to kill someone instantly with poison
- How long a prison sentence you would receive for murdering family members

Planning has been identified by Dr Monckton-Smith as a step in the timeline that offenders often travel in relation to them murdering their partners. This research can also be used in this case as the steps taken by Tomasz prior to the killing of Anna. The internet has given people instant access to any question they wish to ask and is often used, as by Tomasz above, as a premeditated tool to either harm people or commit murder.

16.4.6 There were also searches regarding child protection and where to go if you have family problems.

16.4.7 The use of technology to perpetrate domestic abuse, referred to as tech abuse, has become increasingly common. Domestic abuse charity Refuge reported that in 2019, 72% of women said that they had been subjected to technology-facilitated abuse. Common devices such as smartphones and tablets can be misused to stalk, harass, impersonate, and threaten victims. Some groups have raised concerns that the growing use of internet-related home devises may provide perpetrators with a wider and more sophisticated range of tools to harm victims[12].

16.4.8 The Home Office Department for Digital, Culture, Media and Sport published their Online Harms White Paper in 2020. The paper highlights the real harm which people face online every day. It identifies that in the wrong hands there is a link between internet usage and the spread of terrorism and other illegal or harmful content which could undermine civil discourse and be used to be abusive or bully other people. Online harms are widespread and can have serious consequences. The White Paper puts forward plans for a new system of accountability and oversight for tec companies which will mean that companies have the responsibility to keep UK users, particularly children, safer online with the most robust action to counter illegal content and activity. No date has yet been confirmed for the Bill's remaining stages.

[12] Lorna Christe and Susie Wright, Post Parliament Rapid Response, '*Technology and domestic abuse' 2020*

16.5 Previous Domestic Homicide Review from 2013

16.5.1 A DHR took place in Hertfordshire in 2013 following the sad death of a Polish woman murdered by her husband. This review resulted in similar findings and learnings regarding the impact and awareness of domestic abuse throughout the Polish community living in England. The learnings and recommendations are below and unfortunately show a stark alignment to the learnings from this review. The panel were concerned that it appeared that the same barriers for Eastern Europeans living in Hertfordshire were still there.

16.5.2 **Domestic Abuse**

The review found that in Polish culture, attitudes towards domestic abuse are quite different from commonly held attitudes in the UK. It was identified that current attitudes within the Polish community were rooted within Soviet-era Poland pre-1988 and that, although modified somewhat by exposure to UK attitudes, the old values still generally prevailed.

These attitudes were summarised as “Message from mothers to daughters – be good to husband, look after family, security and good job”. It was felt that, in general, that these beliefs are still adhered to by many.

16.5.3 **Attitude to authorities**

A panel member with expertise on Polish culture believed there was a general reluctance to engage with authorities because of a fear that, once the state becomes involved in family lives, “things can get bad”.

16.5.4 **Attitude to domestic abuse**

During the review, it was stated that the approach to domestic abuse in Poland had improved over the last 10 years, but that there was still an assumption that the offender would remain within the household. The process described is that the Police are the lead agency and on attendance at a domestic abuse incident, will provide the victim with what is termed as a “blue form”, which can assist the victim in obtaining a place within a refuge. However, the system was described as fragmented with little support from social services.

16.5.5 **Access to Information**

It is felt that Polish people living in the UK communities often do not know where to go for accurate information. Further investigation of this made clear that

within the Polish Community, there was a lack of understanding around which agencies are responsible for delivery of which services, and that overlap caused confusion. For example, victims of domestic abuse are often confused as to whether to go to the police, doctor, social services, local authority, or a voluntary agency. The result, it was felt, was that domestic abuse goes unreported.

16.5.6 **Community Barriers**

It was stated that the Polish community was not treated equitably when compared with other identifiable immigrant communities. Examples of this are:

- Very little information being available in Polish on several subjects
- Very little representation in local democracy or service providers
- Very poor access to translation services.

It was felt that this has led to an expectation that few services will be provided to Polish victims of domestic abuse.

Four clear recommendations, which address the issues raised above, were identified during the review. These were to:

- Clearly establish geographic locations of minority communities

- Review and develop knowledge and awareness of domestic abuse within identified minority communities

- Review and develop accredited domestic awareness training for staff across statutory and third sector agencies

- Review and establish where required, provision of interpreting facilities across agencies

17. Conclusions and lessons to be learnt

17.1 The cross-government definition of domestic abuse is:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality, there is very limited data or unavailable data available regarding violence against parents perpetrated by their off springs.*

17.2 It has been identified that it is difficult to obtain information where domestic abuse is being perpetrated by a child on a parent. This means that this is a subject that agencies are not always aware of, and therefore they do not provide the specific help and support required.

17.3 Most guidance on domestic abuse available to professionals is reflective of intimate partner abuse. In turn, domestic abuse tools and assessments used by agencies are geared toward this and may not be suitable to other forms of domestic abuse

17.4 The Domestic Abuse Stalking and Honour based violence (DASH) risk assessment tool[13] is specific to intimate relationships and is not particularly relevant to instances of familial domestic abuse[14].

17.5 Standing Together Against Domestic Violence (STADV) recently produced a briefing sheet in relation to Adult Family Violence (AFV).[15] Within the briefing sheet, it is identified that there was a dearth of research into AFV.

17.6 The lack of research means that most of the current guidance and tools for responding to domestic abuse are geared towards intimate partner violence and are therefore potentially unsuitable for dealing with AFV.

17.7 The review panel also identified that the Hertfordshire Police's Domestic Abuse Safeguarding Unit (known as the DAISU) only deal with instances of domestic abuse perpetrated by a current or former intimate partner.

17.8 Other research has shown that 26% of all domestic homicides involved adult family members, most of which involved adult children killing their parents. Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 114 were adult family homicides (28% of all domestic homicides).[16] This is an outstanding number.

17.9 Research has shown that many minority ethnic women experiencing domestic abuse prefer to access support services from a specialist service targeted at their community, and that women from Eastern communities find it difficult to access mainstream services due to the lack of awareness of support services and language barriers.[17]

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[13] https://safelives.org.uk/sites/default/files/resources/Dash%20without%20guidance.pdf
[14] T. Phan, *Fatal Adult Child to Parent Abuse webinar 2021.*
[15] Standing Together against domestic violence "*Adult Family Violence (AFV) Briefing Sheet.*
[16] Office for National Statistics, 2018 ONS.gov.uk "Domestic abuse in England and Wales: year ending March 2017.
[17] In a survey of BAME women accessing services, found that 89% preferred a specialist BAME worker. Thiara, R & R, S. (2012) Vital statistics 2: Key findings on black, minority ethnic and refugee women's and children's experiences of gender-based violence.

17.10 Research carried out during the Refuge Eastern European Outreach Project identified that majority of women in the project required language support. While 16 were able to communicate in some English, 207 women (93%) either needed an interpreter or needed project staff to provide interpretation and language support.[18]

17.11 Agencies should consider various methods to provide outreach in their communities and to provide the information, help and support needed in the appropriate format.

17.12 There were no recorded instances of domestic abuse within Anna's household and very limited agency involvement. This might, however, be due to the family not wishing for agencies to be involved and the feeling that accessing services would result in stigma being attached to the family.

17.13 Some of the information obtained as part of this review has stated that Tomasz had a close relationship with his mother. There is also suggestion that he had concerns regarding the relationship with his father. Tomasz disclosed to a friend that his father used to shout at him, and he asked this friend whether he could go and live with him. On the date of the murder, Tomasz had attended a job interview which was unsuccessful. This may have triggered an escalation and put Anna, and other members of the family, at greater risk of serious harm from Tomasz.

17.14 The family identified that when they had first arrived in England their eldest son, Piotr, struggled at school as he was unable to speak English. As a result of this the family stated that they really wanted Tomasz to do well in school and to get a good job. During the Police investigation it was identified by the family that they were a hard-working family and it was expected that all family members worked hard and contributed to the household. Tensions appeared to exist within the household because Tomasz, in their opinion, had not applied himself to school/college and as such had been unable to get a good job. They stated that on the day of the murder Tomasz had gone to a job interview as a waiter but that he had turned up looking scruffy which is why he did not get the job. They were disappointed in this. The panel felt that the level of support that Tomasz had received from the SfYP was limited and that workers should have delved deeper into Tomasz and his families background to try and understand what was happening and whether there were any family barriers that were blocking Tomasz. The workers appeared to take everything at face value, and either were not aware of any identified issues with Tomasz, i.e., additional

[18] Refuge independent evaluation report: Eastern European Community Outreach Project Dr. Ravi K. Thiara 2011

educational needs, family background or didn't ask any delving, follow up questions.

17.15 Relevant information was not able to be obtained from the school due to there being very limited records surrounding Tomasz's time there. There were records that the school had made a referral around Tomasz's learning ability in year 6 which had been a cause for concern for some time. He had been given support, but this had had little impact. The educational psychologist had been asked to determine why Tomasz was finding learning so difficult so that the curriculum could be made easier for him. Nothing specific was identified by the school records apart from a referral being made to SfYP for additional support. It is recorded that Tomasz was given additional support in lessons and exams to help him but again the panel were unable to identify which support was made available to him. The school did identify that Tomasz's parents would attend parents' evenings and appeared to be very supportive of Tomasz.

17.16 The family feel let down by the college in relation to Tomasz applying for courses and being told that he had to move course after one year. They did not feel that either Tomasz or the family received the appropriate amount of help in choosing the right course and in the application process.

17.17 It is not clear how much of the college course Tomasz completed or why he left, but this information could have helped SfYP understand Tomasz's reasons for dropping out. It may have also prompted a Contextual Safeguarding approach. Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhood, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.[19]

17.18 SfYP have identified a single agency recommendation in relation to staff training. The recommendation seeks to ensure that all SfYP practitioners have direct interactions with young people, use their professional curiosity to identify and understand indicators of abuse and the impact that these could have on the young person's behaviour, education, and aspirations. The recommendation is as follows:

- Training to understand the concept of contextual safeguarding and relevant support mechanisms.

17.19 Tomasz's reasons for leaving college were not probed by the practitioners dealing with Tomasz from this point onwards. The main reason cited for not contacting the college was that the service focuses solely on the young person's

[19] https://www.contextualsafeguarding.org.uk/

needs in the context of careers and education advice. Data protection, and a lack of information sharing agreements, were also cited as inhibitors to seeking (and providing) information from third party organisations.

17.20 The practitioner, when interviewed as part of this review, said that with hindsight, Tomasz did appear to be 'drifting' and was not highly motivated to engage. During the interviews with Tomasz, he presented as a nice, polite young man who was a little shy.

17.21 Both practitioners interviewed felt that language was not a barrier for Tomasz, who had a very good command of spoken English. The practitioners noted that Tomasz had changed his mind several times about the direction of his future but felt this to be quite normal in this particular cohort of young people struggling to achieve the Government's educational standard. The agency's IMR identified the number of missed and unreturned calls made to Tomasz as concerning and something that might have raised questions with professionals.

17.22 SfYP identified a further recommendation for their agency regarding lack of contact with Tomasz. The recommendations below seek to ensure that processes are developed that will help to identify potential young people (lost contacts) who may fall through the gaps for support.

- Development of a 'flag' system for the KIT team, for when a young person has been particularly difficult to contact.

- Process to be developed for follow up with school, parent, college, or workplace when a young person reaches the 'flagged' stage.

17.23 There is also information suggesting that Anna had a degree of alcohol dependency and that she had recently spent money the family had set aside for Christmas on alcohol, which apparently 'caused tensions' within the household. Tomasz's friend also identified that Tomasz would not let him into his home address and that he would have to wait outside when he visited. This appeared to be unusual, as Tomasz would always go into his friends' home when he visited him. This appears to indicate that either friends of Tomasz were not welcome in the address or Tomasz himself did not want them to come in.

17.24 Tomasz left college after one year of his two-year course. It appears that he also struggled getting a job. This was around the same time Anna attended an AA meeting and when the family were also in rent arears, suggesting they may have been struggling financially. Tomasz's friend also identified that the last time he had seen him, which was close to the date of the murder, he noticed that Tomasz appeared to be unkempt and had smelt unclean.

17.25 Following Anna's murder, police reviewed Tomasz's internet history and found a substantial amount of internet searches in relation to ways to kill your family, including how to buy a gun and using poison. There was also evidence to suggest that Tomasz was very unhappy and was looking for support, as he had also searched ways to contact child protection and where to go if you had family problems. These searched had taken place one month prior to the murder.

17.26 Although a previous DHR has identified learnings to this review, agencies have identified that a considerable amount of work has taken place regarding signposting and offering support to non-English speaking nationals. The Hertfordshire Sunflower Partnership offers help and support for victims of abuse including sexual abuse and physical abuse. The Sunflower Partnership is easily accessible on the internet and can be translated into numerous languages. The Sunflower Partnership also links into the Herts Domestic Abuse Helpline which offers a confidential and free support and signposting service for anyone affected by domestic abuse.

17.27 Hertfordshire Independent Domestic Violence Advocacy (IDVA) service offers support to survivors of domestic abuse from all backgrounds and interpreting services are always used to support those who need language support. The service has also recruited IDVAs who speak several difference languages, including Polish.

17.28 In 2008, Refuge identified a need for additional support for Eastern Europeans who were living in England and set up a service to offer that additional help and support. This support has had a significant impact on the help and support available and is something that should be considered as a priority within Hertfordshire.

18. Recommendations

1. Hertfordshire County Council Domestic Abuse Strategic Partnership Board, when recommissioning their domestic abuse services, to ensure the specification requires providers to demonstrate how they will ensure their service is accessible and removes barriers to access for Eastern European's and other marginalised communities within Hertfordshire. This will include their literature/website etc.

2. When the Hertfordshire County Council Domestic Abuse Strategic Partnership Board develop the new Domestic Abuse strategy a partnership communications strategy will also need to be developed to sit alongside it and be 'owned' by the practice network subgroup.

3. The Hertfordshire County Council Domestic Abuse Strategic Partnership Board to strengthen their existing J9 project[20] to invite more community based organisations (e.g., religious institutions etc.) to become J9 centers. To work with the practice network and providers to scope existing community groups initially within the Eastern European communities and then to expand to other hard to reach communities within Hertfordshire.

4. For individual agencies to review the access to resources to meet the needs of Eastern European communities and other marginalised communities within Hertfordshire, including access to translation and interpreting services where and when required.

5. The Hertfordshire County Council Domestic Abuse Strategic Partnership Board to carry out some deep dives from pathways for minority ethnic and marginalised communities to include a survey of all services in Hertfordshire to identify how they access translation services for victims that might need them.

6. The Chair of the Watford Community Safety Partnership to write to the Brexit lead within the Government to highlight the impact of being a foreign national living in the United Kingdom, because of Brexit, to raise awareness of the 'myths' that now exist within the community.

7. Agencies to review and amend their data collection set to make sure that acts of Adult Family Violence (AFV) are captured and monitored. This recommendation leads into recommendation 8 below.

8. Hertfordshire Community Safety Partnership to work with the local partners to develop and share a greater understanding of the nature and risk factors relating to familial abuse. This includes understanding the dynamics of these cases and the best practice responses to them. This learning should be shared widely throughout Hertfordshire.

[20] The J9 initiative raises awareness of domestic abuse amongst local nosiness and services. It was developed in the memory of Janine Mundy, a mother of two killed by her estranged husband in 2003.

Appendix A: Family's comments on the Overview Report

The family's comments in Polish

W Lutym zapytałem się Tomasz, czy złożył już aplikacje na nowy rok do College Tomasz odpowiedział, że nie, bo jakiś nauczyciel powiedział, że nowa aplikacje na następny rok szkola ma składać dopiero od połowy Sierpnia. Próbowaliśmy mu przemówić do rozsądku kilkukrotnie razem z mamą, ale nie stety Tomasz nie przyjmował tego do wiadomości zeby applikacje na nowy rok w szkole złożyć już w Lutym /Marcu. Potem nie pamiętam dokładnie, w jakim miesiącu Tomasz przyszedł do domu i powiedzail nam rodzinie, że nauczyciele w szkole twierdza, że nieradzi Sabie z nauką na kursie Turystycznym i proponują mu zmianę kierunku kursu na coś innego. Wiec powiedzieliśmy Tomaszowi zeby poszedł i podpytał się, jaki nowy kierunek nauczyciele proponują mu i nauczyciele zaprononowali mu przejście na kurs Biznesu, który w naszej opinie wydawał się jeszcze trudniejszy, a i sam Tomasz nie za bardzo był zadowolony z tej propozycji. Więc wspólnie podpowiedzieliśmy Tomaszowi zeby poszedł na kurs Gastronomiczny, gdyż ja miałem doświadcznie i znajomości w branży gastronomicznej, więc łatwiej, by było załatwić Tomaszowi jakieś ewentualne praktyki, czy nawet etat pracy, a i nawet mama jako gospodyni domowa od wielu lat mogłaby pomc Tomaszowi z podstawami gotowania. Po wielukrotnych namowach Tomasz dał się namówić na aplikowanie do szkoły wcześniej, niż w Sierpniu i Tomasz wyslal aplikajce do szkoły. Która wypełnił niepoprawnie i potem mama poprosiła zeby pomógł Tomaszowi z tą aplikacją i złożyliśmy wspólnie kolejna aplikacje do szkoły na nowy rok w sumie Tomasz wysłał 3 aplikacje do szkoły jedna sam i dwie zemną niestety mijał czas i nie było żadnej odpowiedzi ze strony szkoły, a był już Wrzesień i Tomasz próbował się skontaktować kilkukrotnie z collegem telefonicznie parę razy został poproszony o przyjście osobiście do szkoły, gdzie paru krotnie czekał na nauczycieli wiele godzin proszony, aby poczekać na nich, a potem mówiono mu zeby przyszedł znowu następnym razem. Tomasz był bardzo zdenerwowany tym faktem, że musi chodzić do szkoły czeka po parę godzin i jest odsyłane do domu bez załatwienia sprawy. Po jakimś czasie po rozmowach z Tomaszem i usłyszeniu od niego na czym sprawa stanęła zacząłem osobiście kontaktować się z collegem w sprawie Tomasza. Sprawa była notorycznie przedłużana, a to ktoś miał przekazać, że ja dzwoniłem w spawie Tomasz głównemu nauczycielowi, który miał do mnie oddzwonić, lecz nigdy tak się nie stało i po kolejnym telefonie do szkoły dowiadywałem się, że nikt nie przekzal nic głównemy nauczycielowi i dlatego do mnie nie odzwonil. Po wielu telefona rozmowach z dyrektorem college usłyszałem, że niestety Tomasz złożył aplikacje za późno i już nie ma dla niego miejsca i nie da się już nic dla niego zrobić musi wrócić do edukacji za rok.

The family's comments translated into English

Please note that the follow translation has been checked by the family and they are happy with the wording

In February, I asked Tomasz if he had already submitted applications for the New Year to the College. Tomasz replied that he had not, because some teacher said that the new application for the next year the school is to submit only from mid-August.

We tried to talk him to reason several times together with my mother, Tomasz did not accept it in order to submit apps for the New Year at school in February / March. Then I don't remember exactly what month Tomasz came home and told our family that the teachers at school said that he would not advise Tomasz to study at the Tourist course and offered him to change the direction of the course to something else.

So we told Tomasz to go and ask what new direction the teachers were proposing to him and the teachers had prevented him from switching to the Business course, which in our opinion seemed even more difficult, and Tomasz himself was not very happy with this proposal.

So together we suggested to Tomasz to go to the Catering course, because I had experience and acquaintances in the catering industry, so it would be easier to arrange for Tomasz to get some possible internships, or even a full-time job, and even his mother as a housewife for many years could help Tomasz with the basics of cooking.

After many persuasions, Tomasz was persuaded to apply to school earlier than in August and Tomasz sent an application to the school. Who filled in incorrectly and then mom asked him to help Tomasz with this application and we submitted together another application to the school for the new year in total Tomasz sent 3 applications to the school one on his own and two with help from his family unfortunately time passed and there was no response from the school, and it was already September and Tomasz tried to contact the college several times by phone, several times he was asked to come to the school in person, where several times he waited for the teachers for many hours asked to wait for them, and then he was told to come again the next time.

Tomasz was very upset by the fact that he had to go to school waiting for a few hours and was sent home without settling the matter.

After some time, after talking to Tomasz and hearing from him what the matter was about, I began to personally contact the college about Tomasz. The case was notoriously prolonged, and it was someone who was supposed to convey that I was calling Thomas to the main teacher, who was supposed to call me back, but it never happened and after another phone call to the school I found out that no one had transferred anything to the main teacher and therefore he did not call me back. After many phone calls with the headmaster of the college, I heard that unfortunately Tomasz submitted applications too late and there is no place for him and nothing can be done for him he must return to education in a year.

The family feel that the above mistakes and lack of care by the school, lead to Tomasz leaving the Education system, without a job, and with no ongoing education, and pressure from the family to get a job: the family believe this had a part to play in the actions that followed by Tomasz.

The family believed Tomasz was a shy teenager, and they are sorry they didn't recognise that Tomasz was struggling.